STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675434	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Pines Nursing and Rehabilitation Center	503 Old Austin Highway Bastrop, TX 78602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on observations, record review, and interviews the facility failed to update the Resident's (#57) care plan in relation to changes in health, changes in behavior and significant changes for one (Resident #57) out of 8 residents reviewed. The facility failed to update Resident #57's care plan and adjust it in relation to physician orders. The deficient practice could affect residents by delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of the Face Sheet for Resident #57 reflected he was admitted on [DATE] with diagnosis of: COPD, a single Pulmonary Nodule, Atrial Fibrillation, Heart Failure, Type 2 Diabetes, Morbid Obesity, Major Depressive disorder, acute and chronic respiratory failure with hypoxia, and obstructive uropathy. Review of the MDS assessment for Resident #57 dated 3/18/24 reflected a BIMS score of 15 indicating normal cognitive function. His physical assessment reflected he required supervision or one person assistance for all ADLs. He was assessed as occasionally incontinent of bowel and had a Foley catheter in place. Review of the Care Plan for Resident #57 reflected interventions were in place for: drug allergies, DNR status, ADL self-performance deficit r/t Dementia, Limited mobility d/t heart failure, Refusing to wear BiPAP breathing assist, Diabetes, Fall Risk, Foley catheter, behavior of Insomnia, Rash to right back r/t Herpes zoster (Shingles), Oxygen therapy. No changes related to diagnosis of UTI, Antibiotics or confused behaviors. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes for Resident #57 reflected on 5/23/24 he demonstrated increased level of confusion. On 5/23/24 the Nurse Practitioner changed the antibiotic for the UTI to Cipro 500 mg twice a day. On 5/21/24 the resident was sent to hospital after a fall without injury. He was observed by staff on the floor face down and his brief was around his ankles. Resident #57 stated he had turned off his oxygen concentrator because a doctor was in the room talking to him. On 5/20/24 the resident was continued on Keflex antibiotic 500 mg every 12 hours and Valacyclovir 500 mg every 8 hours for Shingles. On 5/19/24 Resident #57's antibiotic was changed to Keflex 500 mg every 12 hours for UTI. Resident #57 was previously sent to hospital on 5/18/24 for confusion and shaking. Observation and interview at 10:47 am on 5/21/24 revealed Resident #57 had fallen from his bed to the floor. He was face down on the floor with his brief around his ankles. His catheter remained in place, draining clear yellow urine. Two staff were at bedside attempting to assist him. LVN C and a NA, LVN E entered the room. He stated Resident #57 was confused and had become more confused since yesterday. He stated Resident #57 had gone out to hospital for a Shingles infection this weekend and they also diagnosed a UTI, he was receiving antibiotics for both. The Resident stated he had slipped in water at bedside attempting to reach pants on his bedside table. No pants were visible on the bedside table. Resident #57 argued with staff some as they put down towels to soak up water. In an interview on 5/21/24 at 11:10 am LVN C stated she was summoned to Resident #57's room by a housekeeper who stated Resident #57 had fallen. LVN C stated he had not worked with Resident #57 for a while, but he was definitely more confused than normal. He stated Resident #57 indicated he was not hurt in the fall. LVN C stated Resident #57 was able to sit up and then sat in his wheelchair to transfer back to bed. LVN C stated Resident #57 had cardiac and respiratory problems which limited his ability to perform ADLs. The LVN C stated Resident #57 may need to return to hospital for evaluation. In an interview on 5/23/24 at 8:55 am Resident #57 stated he was unsure why he had removed his clothing and his brief prior to his fall. Resident #57 stated he did not recall the fall; he stated his confusion could be related to his UTI or his Shingles outbreak. Observation revealed his Foley catheter was draining clear yellow urine. Resident #57 was receiving a breathing/nebulizer treatment at the time of the interview. In an interview on 5/23/24 at 9:30 am LVN A stated Resident #57 had a history of removing his briefs. She stated she was not sure if the behavior was related to his dementia or his recent UTI. In an interview on 5/23/24 at 9:35 am the DON stated the facility had been actively watching Resident #57. She stated he was sent to hospital the first time for a UTI, but the antibiotics prescribed did not yield the desired effect. She stated he was sent out a second time on 5/21/24 after he fell from bed. The DON stated Resident #57 was monitored because he had a Foley catheter. The DON stated his behavior could be added to care plan pointing out his fall was the first incident of #57 removing his brief she had found. The DON stated staff should have followed policy and covered Resident #57 to protect his dignity. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/24 at 11:50 am the Administrator stated Resident #57 came down with a UTI on 5/18/24 and was sent out to hospital. She stated interventions could have been added to deal with his confusion, disrobing behaviors and other symptoms of the UTI. She stated other than the fall on 5/21/24 no other falls were noted for Resident #57, the surveyor pointed out he was listed as a high fall risk. The Administrator stated when Resident #57 was observed with his brief down around his ankles or incontinent of bowel staff should have taken action to protect his dignity. She stated the door should have been closed during care, curtains pulled, and the resident covered. Surveyor stated after Resident #57 fell three staff were in the room (C, [NAME], A) and no one took measures to protect the resident's dignity. She stated staff should have responded to the situation wholly. Review of the Facility's Care Plan Development Policy dated October 2022 reflected the care plan must be updated within 7 days of a comprehensive MDS assessment. The facility's rational for proceeding with care planning will be evidenced in the clinical record (such as a change in condition).